AN ACT

RELATING TO MEDICAID; PRESERVING ACCESS TO MEDICAID SERVICES; PROVIDING DUE PROCESS TO MEDICAID PROVIDERS AND SUBCONTRACTORS; PROVIDING FOR INDEPENDENT ADMINISTRATIVE LAW JUDGES; ESTABLISHING PROCEDURES TO RESOLVE OVERPAYMENT DISPUTES; PROVIDING FOR JUDICIAL REVIEW OF A CREDIBLE ALLEGATION OF FRAUD DETERMINATION; CLARIFYING THE DEFINITION OF "MEDICAID FRAUD".

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 27-11-1 NMSA 1978 (being Laws 1998, Chapter 30, Section 1) is amended to read:

"27-11-1. SHORT TITLE.--Chapter 27, Article 11 NMSA 1978 may be cited as the "Medicaid Managed Care and Provider Act"."

SECTION 2. Section 27-11-2 NMSA 1978 (being Laws 1998, Chapter 30, Section 2) is amended to read:

"27-11-2. DEFINITIONS.--As used in the Medicaid Managed Care and Provider Act:

A. "claim" means a request for payment for services;

B. "clean claim" means a claim for reimbursement that:

(1) contains substantially all the required data elements necessary for accurate adjudication of the

claim without the need for additional information from the medicaid provider or subcontractor;

(2) is not materially deficient or improper, including lacking substantiating documentation required by medicaid; and

(3) has no particular or unusual circumstances that require special treatment or that prevent payment from being made in due course on behalf of medicaid;

C. "credible" means having indicia of reliability after the state has reviewed all allegations, facts and evidence carefully and acted judiciously on a case-by-case basis;

D. "credible allegation of fraud" means an allegation that has been verified by the state from any source, including fraud hotline complaints, claims data mining and provider audits;

E. "department" means the human services department;

F. "fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person, including any act that constitutes fraud under state or federal law;

G. "managed care organization" means a person eligible to enter into risk-based prepaid capitation

agreements with the department to provide health care and related services;

H. "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

I. "medicaid provider" means a person, other than a managed care organization, operating under contract with the department to provide medicaid-related services to recipients;

J. "overpayment" means an amount paid to a medicaid provider or subcontractor in excess of the medicaid allowable amount, including payment for any claim to which a medicaid provider or subcontractor is not entitled;

K. "person" means an individual or other legal entity;

L. "recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;

M. "secretary" means the secretary of human services; and

N. "subcontractor" means a person who contracts with a medicaid managed care organization or a medicaid provider to provide medicaid-related services to recipients."

SECTION 3. Section 27-11-3 NMSA 1978 (being Laws 1998, Chapter 30, Section 3, as amended) is amended to read:

"27-11-3. REVIEW OF MEDICAID MANAGED CARE ORGANIZATION--CONTRACT REMEDIES--PENALTIES.--

A. Consistent with the terms of any contract between the department and a medicaid managed care organization, the secretary shall have the right to be afforded access to such of the medicaid managed care organization's records and personnel, as well as its subcontracts and that subcontractor's records and personnel, as may be necessary to ensure that the medicaid managed care organization is complying with the terms of its contract with the department.

B. Upon not less than two days' written notice to a medicaid managed care organization, the secretary may, consistent with the provisions of the Medicaid Managed Care and Provider Act and rules issued pursuant to that act, carry out an administrative investigation or conduct administrative proceedings to determine whether a medicaid managed care organization has:

(1) materially breached its obligation to furnish medicaid-related services to recipients, or any other duty specified in its contract with the department;

(2) violated any provision of the Public Assistance Act or the Medicaid Managed Care and Provider Act or any rules issued pursuant to those acts;

(3) intentionally or with reckless disregard

made any false statement with respect to any report or statement required by the Public Assistance Act or the Medicaid Managed Care and Provider Act, rules issued pursuant to either of those acts or a contract with the department;

(4) intentionally or with reckless disregard advertised or marketed, or attempted to advertise or market, its services to recipients in a manner as to misrepresent its services or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing;

(5) hindered or prevented the secretary from performing any duty imposed by the Public Assistance Act, the Human Services Department Act or the Medicaid Managed Care and Provider Act or any rules issued pursuant to those acts; or

(6) fraudulently procured or attempted to procure any benefit from medicaid.

C. Subject to the provisions of Subsection D of this section, after affording a medicaid managed care organization written notice of hearing not less than ten days before the hearing date and an opportunity to be heard, and upon making appropriate administrative findings, the secretary may take any or any combination of the following actions against the medicaid managed care organization:

(1) impose an administrative penalty of not

more than five thousand dollars ($5,000) for engaging in any practice described in Subsection B of this section; provided that each separate occurrence of such practice shall constitute a separate offense;

(2) issue an administrative order requiring the medicaid managed care organization to:

(a) cease or modify any specified conduct or practices engaged in by it or its employees, subcontractors or agents;

(b) fulfill its contractual obligations in the manner specified in the order;

(c) provide any service that has been denied;

(d) take steps to provide or arrange for any service that it has agreed or is otherwise obligated to make available; or

(e) enter into and abide by the terms of a binding or nonbinding arbitration proceeding, if agreed to by any opposing party, including the secretary; or

(3) suspend or revoke the contract between the medicaid managed care organization and the department pursuant to the terms of that contract.

D. If a contract between the department and a medicaid managed care organization explicitly specifies a dispute resolution mechanism for use in resolving disputes

over performance of that contract, the dispute resolution mechanism specified in the contract shall be used to resolve such disputes in lieu of the mechanism set forth in Subsection C of this section.

E. If a medicaid managed care organization's contract so specifies, the medicaid managed care organization shall have the right to seek de novo review in district court of any decision by the secretary regarding a contractual dispute."

SECTION 4. Section 27-11-4 NMSA 1978 (being Laws 1998, Chapter 30, Section 4, as amended) is amended to read:

"27-11-4. RETENTION AND PRODUCTION OF RECORDS.--

A. Medicaid managed care organizations, medicaid providers and their subcontractors shall retain, for a period of at least six years from the date of creation, all medical and business records that are necessary to verify the:

(1) treatment or care of any recipient for which the medicaid managed care organization, medicaid provider or subcontractor received payment from the department to provide that benefit or service;

(2) services or goods provided to any recipient for which the medicaid managed care organization, medicaid provider or subcontractor received payment from the department to provide that benefit or service;

(3) amounts paid by medicaid or the medicaid

managed care organization on behalf of any recipient; and

(4) records required by medicaid under any contract between the department and the medicaid managed care organization.

B. Upon written request by the department to a medicaid managed care organization, medicaid provider or any subcontractor for copies or inspection of records pursuant to the Public Assistance Act, the medicaid managed care organization, medicaid provider or subcontractor shall provide the copies or permit the inspection, as applicable within two business days after the date of the request unless the records are held by a subcontractor, agent or satellite office, in which case the records shall be made available within ten business days after the date of the request.

C. Failure to provide copies or to permit inspection of records requested pursuant to this section shall constitute a violation of the Medicaid Managed Care and Provider Act within the meaning of Paragraph (3) of Subsection B of Section 27-11-3 NMSA 1978."

SECTION 5. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"DETERMINATION OF OVERPAYMENTS--AUDIT FINDINGS--SAMPLING--EXTRAPOLATION PROHIBITED--NOTICE OF RIGHT TO INFORMAL CONFERENCE AND EXPEDITED ADJUDICATORY PROCEEDING.--

A. The department may audit a medicaid provider or

subcontractor for overpayment, using sampling for the time period audited. Each audited claim shall be reviewed by a person who is licensed, certified, registered or otherwise credentialed in New Mexico as to the matters such person reviews, including coding or specific clinical practice.

B. The department shall not extrapolate audit findings.

C. Prior to reaching a final determination of overpayment, including an overpayment based in whole or in part on a credible allegation of fraud, the department shall serve the medicaid provider or subcontractor with a written tentative finding of overpayment.

D. The tentative finding of overpayment shall:

(1) state with specificity the factual and legal basis for each claim forming the basis of an alleged overpayment;

(2) include a copy of the final audit report if the alleged overpayment is based on an audit; and

(3) notify the medicaid provider or subcontractor that is the subject of a tentative finding of overpayment of the medicaid provider's or subcontractor's right to request, within thirty calendar days of service of the tentative finding of overpayment:

(a) an informal conference with a representative of the department who is knowledgeable about

the department's tentative finding of overpayment and with a member of the audit team, if an audit formed the basis of any alleged overpayment, to informally address, resolve or dispute the department's tentative finding of overpayment; and

(b) an expedited adjudicatory proceeding pursuant to the Administrative Procedures Act to challenge the department's tentative finding of overpayment.

E. Prior to making a final determination of overpayment, including an overpayment based in whole or in part on a credible allegation of fraud, the department may impose corrective action upon the medicaid provider or subcontractor to address systemic conditions contributing to errors in the submission of claims for payment to which a medicaid provider or subcontractor is not entitled."

SECTION 6. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"INFORMAL CONFERENCE--REQUIREMENTS.--

A. A medicaid provider or subcontractor seeking an informal conference pursuant to this section shall serve the department with a written request for such conference no later than thirty calendar days following the service of a tentative finding of overpayment by the department on the medicaid provider or subcontractor. Upon receipt of a request for an informal conference, the department shall set

a date for the conference to occur no later than fourteen business days following receipt of the request.

B. The medicaid provider or subcontractor shall have no less than thirty calendar days following the informal conference to:

(1) provide additional documentation to the department to attempt to informally address or resolve a disputed tentative finding of overpayment; and

(2) correct clerical, typographical, scrivener's and computer errors or to provide requested credentialing, licensure or training records.

C. A medicaid provider's or subcontractor's decision to seek an informal conference pursuant to this section does not extend the time by which the medicaid provider or subcontractor shall request an expedited adjudicatory proceeding pursuant to Section 7 of this 2017 act. The informal resolution process shall run concurrently with the expedited adjudicatory proceeding, and the informal resolution process shall be discontinued once the presiding administrative law judge issues findings of fact and conclusions of law with respect to the department's tentative finding of overpayment."

SECTION 7. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"EXPEDITED ADJUDICATORY PROCEEDINGS--REQUIREMENTS.--

A. A medicaid provider or subcontractor seeking an expedited adjudicatory proceeding pursuant to the Medicaid Managed Care and Provider Act shall serve the department and the administrative hearings office with a written request for such proceeding no later than thirty calendar days following the service of a tentative finding of overpayment by the department on the medicaid provider or subcontractor.

B. The chief hearing officer of the administrative hearings office shall appoint a presiding administrative law judge no later than thirty calendar days after service upon the administrative hearings office of a request for an expedited adjudicatory proceeding pursuant to the Medicaid Managed Care and Provider Act by a medicaid provider or subcontractor.

C. The expedited adjudicatory proceeding requested by a medicaid provider or subcontractor in accordance with the Medicaid Managed Care and Provider Act shall commence no later than thirty calendar days following the appointment of the presiding administrative law judge or as stipulated by the parties or as otherwise ordered by the presiding administrative law judge upon a showing of good cause. The evidentiary hearing of an expedited adjudicatory proceeding pursuant to this section shall not exceed ten business days in length and shall be conducted in accordance with Section 12-8-11 NMSA 1978.

D. After affording the parties the opportunity to submit proposed findings and conclusions of law, and based solely upon the record in accordance with the Medicaid Managed Care and Provider Act and the Administrative Procedures Act, the presiding administrative law judge shall make findings of fact and conclusions of law on all material issues of fact, law or discretion, stating the basis for each. In addition, the presiding administrative law judge shall determine the amount of overpayment with respect to each disputed claim submitted for payment, if any. The findings of fact and conclusions of law of the presiding administrative law judge shall be made and served upon all parties of record within thirty calendar days following the presiding administrative law judge's receipt of the record.

E. The presiding administrative law judge's findings of fact and conclusions of law shall be binding on the department and constitute a final agency decision, which may be appealed pursuant to Section 39-3-1.1 NMSA 1978."

SECTION 8. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"QUALIFICATIONS AND SELECTION OF ADMINISTRATIVE LAW JUDGE FOR EXPEDITED ADJUDICATORY PROCEEDINGS.--

A. The administrative law judge presiding over the expedited adjudicatory proceeding held pursuant to the Medicaid Managed Care and Provider Act shall:

(1) be licensed and in good standing to practice law in New Mexico or another state;

(2) have at least three years' cumulative experience in one or more of the following areas: the health insurance industry, the medicaid program, health care regulatory compliance, medical claims administration or health law;

(3) have at least five years' experience in commercial litigation demonstrating the ability to make a record in an adjudicatory proceeding suitable for judicial review;

(4) not currently be employed by or represent, or belong to a law firm that currently represents, the state or a medicaid managed care organization or third party administrator currently doing business with the department; and

(5) not be related within the third degree of consanguinity to a person currently employed by an executive agency of the state, currently doing business with the state or currently employed by an organization doing business with the state.

B. The chief hearing officer of the administrative hearings office shall select an administrative law judge to preside over an expedited adjudicatory proceeding held pursuant to the Medicaid Managed Care and Provider Act and

the Administrative Procedures Act."

SECTION 9. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"COSTS OF EXPEDITED ADJUDICATORY PROCEEDING.--

A. The department shall be responsible for the costs of the administrative law judge.

B. Each party shall be responsible for its own costs related to the expedited adjudicatory proceeding, including costs associated with preparation for the hearing, discovery, depositions, subpoenas, service of process and witness expenses, travel expenses and investigation expenses and attorney fees.

C. The administrative law judge shall allow telephonic testimony of a witness if requested by a party."

SECTION 10. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"RIGHTS OF MEDICAID PROVIDER OR SUBCONTRACTOR--TENTATIVE OR FINAL DETERMINATION OF OVERPAYMENT.--

A. A medicaid provider or subcontractor may challenge the accuracy of the department's audit, the credentials of the persons who participated in the audit or claims review or the good faith of a prepayment review of claims and may present evidence to dispute any matter or methodology forming the basis of a tentative or final determination of overpayment.

B. A medicaid provider or subcontractor may, but shall not be required to, conduct its own audit or sampling to challenge a tentative or final determination of overpayment."

SECTION 11. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"RELEASE OF SUSPENDED PAYMENT FOR SERVICES PREVIOUSLY RENDERED--PREPAYMENT REVIEW--REMEDIAL TRAINING AND EDUCATION--TEMPORARY ASSISTANCE.--

A. The department shall release a suspended payment to a medicaid provider or subcontractor that is the subject of a referral based upon a determination of a credible allegation of fraud for services previously rendered if the medicaid provider or subcontractor posts a surety bond in the amount of the suspended payment, which posting shall be deemed good cause not to suspend payment.

B. The provisions of this section shall not prevent the department from:

(1) conducting a good-faith prepayment review of claims for ongoing services rendered by the medicaid provider or subcontractor;

(2) requiring the medicaid provider or subcontractor or its employees to complete remedial training or education to prevent the submission of claims for payment to which the medicaid provider or subcontractor is not

entitled; or

(3) requiring the medicaid provider or subcontractor to engage an independent third party approved by the department to temporarily manage or provide technical assistance to the medicaid provider or subcontractor.

C. The department shall release a suspended payment no later than ten business days following the earlier of:

(1) the posting of a surety bond by the medicaid provider or subcontractor in the amount of the suspended payment;

(2) notice from the attorney general that the attorney general will not pursue legal action against the medicaid provider or subcontractor arising out of the referral of the medicaid provider or subcontractor based on a determination of a credible allegation of fraud;

(3) the date on which an administrative decision as to the basis for suspending such payments, or portion of such payments, in favor of the medicaid provider or subcontractor becomes final; or

(4) the date on which a judicial decision as to the basis for suspending such payments, or portion of such payments, in favor of the medicaid provider or subcontractor becomes final and not subject to further appeal."

SECTION 12. A new section of the Medicaid Managed Care

and Provider Act is enacted to read:

"MAINTENANCE OF SERVICES--PAYMENT FOR ONGOING SERVICES.--

A. Following the referral of a medicaid provider or contractor based on a determination of a credible allegation of fraud, and during the pendency of a dispute between the department and a medicaid provider or subcontractor regarding an alleged overpayment, including an overpayment based in whole or in part on a credible allegation of fraud, the department shall not terminate or deny the medicaid provider's or subcontractor's continued participation in the state's medicaid program if the medicaid provider or subcontractor:

(1) submits to a good-faith prepayment review of claims for ongoing services;

(2) demonstrates that its employees have completed remedial training or education required by the department to prevent the submission of claims for payment to which the medicaid provider or subcontractor is not entitled; and

(3) engages an independent third party approved by the department to temporarily manage or provide technical assistance to the medicaid provider or subcontractor following the referral or during the pendency of the dispute.

B. The department shall not unreasonably withhold approval of a third party proposed by the medicaid provider or subcontractor pursuant to Paragraph (3) of Subsection A of this section.

C. A medicaid provider or subcontractor that complies with the requirements of Subsection A of this section shall be reimbursed for each clean claim for ongoing services within ten calendar days of receipt if submitted electronically or thirty calendar days if submitted manually."

SECTION 13. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"DISPOSITION OF RECOVERED MEDICAID FUNDS.--

A. Overpayments collected pursuant to the Medicaid Managed Care and Provider Act on behalf of the state shall be remitted to the state treasurer for deposit in the general fund to be used for the state's medicaid program.

B. The department shall not pay any portion of funds recovered by the state from a medicaid managed care organization or a medicaid provider or subcontractor to any other person unless expressly authorized or required to do so by state or federal law."

SECTION 14. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"CREDIBLE ALLEGATION OF FRAUD--JUDICIAL REVIEW--

SUBSTANTIAL EVIDENCE REQUIRED.--

A. A credible allegation of fraud determination by the department shall be deemed a final agency decision and may be appealed pursuant to Section 39-3-1.1 NMSA 1978.

B. A medicaid provider or subcontractor who is the subject of a referral to the attorney general for further investigation based on a credible allegation of fraud may seek judicial review, pursuant to Section 39-3-1.1 NMSA 1978, of the department's determination that the allegation of fraud is credible. The department shall show by substantial evidence that:

(1) it has not abused its discretion by failing to follow its own procedures; and

(2) the evidence relied upon to make its credible allegation of fraud determination was relevant, credible and material to the issue of fraud.

C. In a proceeding for judicial review under this section, the reviewing court shall not consider evidence acquired by the department after making its credible allegation of fraud determination."

SECTION 15. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"AWARD OF COSTS, FEES AND INTEREST.--

A. If a medicaid provider or subcontractor is the prevailing party in any expedited adjudicatory or court

proceeding brought by the medicaid provider or subcontractor pursuant to the Medicaid Managed Care and Provider Act on or after July 1, 2017 in connection with a tentative or final determination of overpayment or of credible allegation of fraud, the medicaid provider or subcontractor shall be entitled to:

(1) reasonable administrative costs incurred in connection with an expedited adjudicatory proceeding with the department;

(2) reasonable litigation costs incurred in connection with a court proceeding; and

(3) interest pursuant to Subsection F of this section.

B. As used in this section:

(1) "court proceeding" means any civil action brought in state district court;

(2) "reasonable administrative costs" means actual charges for:

(a) court reporter fees, service of process fees and similar expenses;

(b) the services of expert witnesses;

(c) any study, analysis, report, test or project reasonably necessary for the preparation of the party's case; and

(d) fees and costs paid or incurred for

the services of attorneys or of certified public accountants in connection with the expedited adjudicatory proceeding; and

(3) "reasonable litigation costs" means:

(a) reasonable court costs; and

(b) actual charges for: 1) filing fees, court reporter fees, service of process fees and similar expenses; 2) the services of expert witnesses; 3) any study, analysis, report, test or project reasonably necessary for the preparation of the party's case; and 4) fees and costs paid or incurred for the services of attorneys or certified public accountants in connection with the proceeding.

C. For purposes of this section:

(1) the medicaid provider or subcontractor is the prevailing party if it has:

(a) substantially prevailed with respect to the amount in controversy; or

(b) substantially prevailed with respect to most of the issues involved in the case or the most significant issue or set of issues involved in the case;

(2) the medicaid provider or subcontractor shall not be treated as the prevailing party if, prior to July 1, 2017, the department establishes or, on or after July 1, 2017, the presiding administrative law judge finds that the position of the department in the proceeding was based

upon a reasonable application of the law to the facts of the case. For purposes of this paragraph, the position of the department shall be presumed not to be based upon a reasonable application of the law to the facts of the case if:

(a) the department did not follow its own rules or procedures in making a tentative finding or final determination of overpayment; or

(b) the department's tentative finding or final determination of overpayment giving rise to the proceeding was not supported by substantial evidence at the time such finding or determination was made; and

(3) the determination of whether the medicaid provider or subcontractor is the prevailing party and the amount of reasonable administrative costs or reasonable litigation costs shall be made:

(a) by agreement of the parties;

(b) in an expedited adjudicatory proceeding, by the presiding administrative law judge; or

(c) in a court proceeding, by the court.

D. A decision or order granting or denying in whole or in part an award for reasonable administrative costs pursuant to Subsection A of this section by the presiding administrative law judge shall be reviewable in the same

manner as a decision of an administrative hearing officer. An order granting or denying in whole or in part an award for reasonable litigation costs pursuant to Subsection A of this section in a court proceeding may be incorporated as a part of the decision or judgment in the court proceeding and shall be subject to appeal in the same manner as the decision or judgment.

E. No agreement for or award of reasonable administrative costs or reasonable litigation costs in any expedited adjudicatory or court proceeding pursuant to Subsection A of this section shall exceed the lesser of thirty percent of the amount of the settlement or judgment or one hundred thousand dollars ($100,000). A medicaid provider or subcontractor awarded administrative or litigation costs pursuant to this section may not receive an award of attorney fees pursuant to any other statutory provision.

F. Interest on amounts owed to a prevailing medicaid provider or subcontractor shall accrue and be paid at the rate of one and one-half percent a month on the amount of a:

(1) clean claim electronically submitted by the medicaid provider or subcontractor and not paid within thirty days of receipt;

(2) clean claim manually submitted by medicaid provider or subcontractor and not paid within

forty-five days of receipt; or

(3) claim for which additional information was necessary to substantiate the claim and not paid within sixty days of receipt of such additional information."

SECTION 16. A new section of the Medicaid Managed Care and Provider Act is enacted to read:

"APPLICABILITY OF ADMINISTRATIVE PROCEDURES ACT.--

A. The department shall be subject to Sections 12-8-2, 12-8-10 through 12-8-13, 12-8-15 and 12-8-16 NMSA 1978 for expedited adjudicatory proceedings as provided by the Medicaid Managed Care and Provider Act.

B. Sections 12-8-2, 12-8-10 through 12-8-13, 12-8-15 and 12-8-16 NMSA 1978 apply to Sections 5, 7 through 12 and 15 of this 2017 act."

SECTION 17. A new section of the Administrative Hearings Office Act is enacted to read:

"APPOINTMENT OF ADMINISTRATIVE LAW JUDGE FOR EXPEDITED ADJUDICATORY PROCEEDINGS UNDER THE MEDICAID MANAGED CARE AND PROVIDER ACT.--The chief hearing officer shall select an administrative law judge for expedited adjudicatory proceedings as provided by the Medicaid Managed Care and Provider Act."

SECTION 18. Section 30-44-7 NMSA 1978 (being Laws 1989, Chapter 286, Section 7, as amended) is amended to read:

"30-44-7. MEDICAID FRAUD--DEFINED--INVESTIGATION--

PENALTIES.--

A. Medicaid fraud consists of:

(1) paying, soliciting, offering or receiving:

(a) a kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the program, including an offer or promise to, or a solicitation or acceptance by, a health care official of anything of value with intent to influence a decision or commit a fraud affecting a state or federally funded or mandated managed health care plan;

(b) a rebate of a fee or charge made to a provider for referring a recipient to a provider;

(c) anything of value, intending to retain it and knowing it to be in excess of amounts authorized under the program, as a precondition of providing treatment, care, services or goods or as a requirement for continued provision of treatment, care, services or goods; or

(d) anything of value, intending to retain it and knowing it to be in excess of the rates established under the program for the provision of treatment, services or goods;

(2) providing with intent that a claim be relied upon for the expenditure of public money:

(a) treatment, services or goods that have not been ordered by a treating physician;

(b) treatment that is substantially inadequate when compared to generally recognized standards within the discipline or industry; or

(c) merchandise that has been adulterated, debased or mislabeled or is outdated;

(3) presenting or causing to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent, excessive, multiple or incomplete claim for furnishing treatment, services or goods; or

(4) executing or conspiring to execute a plan or action to:

(a) defraud a state or federally funded or mandated managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or

(b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed

or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.

B. Unless accompanied by evidence of a culpable mental state, the following shall not constitute medicaid fraud:

(1) a failure to comply with service definitions or guidelines issued by the department or a medicaid managed care organization; or

(2) a breach of contractual terms or provisions.

C. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud as described in Paragraph (1) or (3) of Subsection A of this section is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

D. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud as described in Paragraph (2) or (4) of Subsection A of this section when the value of the benefit, treatment, services or goods improperly provided is:

(1) not more than one hundred dollars ($100) is guilty of a petty misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

(2) more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

(3) more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978;

(4) more than two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is guilty of a third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978; and

(5) more than twenty thousand dollars ($20,000) is guilty of a second degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

E. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in physical harm or psychological harm to a recipient is guilty of a

fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

F. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in great physical harm or great psychological harm to a recipient is guilty of a third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

G. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in death to a recipient is guilty of a second degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

H. If the person who commits medicaid fraud is an entity rather than an individual, the entity shall be subject to a fine of not more than fifty thousand dollars ($50,000) for each misdemeanor and not more than two hundred fifty thousand dollars ($250,000) for each felony.

I. The unit shall coordinate with the human services department, department of health and children, youth and families department to develop a joint protocol establishing responsibilities and procedures, including prompt and appropriate referrals and necessary action regarding allegations of program fraud, to ensure prompt

investigation of suspected fraud upon the medicaid program by any provider. These departments shall participate in the joint protocol and enter into a memorandum of understanding defining procedures for coordination of investigations of fraud by medicaid providers to eliminate duplication and fragmentation of resources. The memorandum of understanding shall further provide procedures for reporting to the legislative finance committee the results of all investigations every calendar quarter. The unit shall report to the legislative finance committee a detailed disposition of recoveries and distribution of proceeds every calendar quarter."

SECTION 19. TEMPORARY PROVISION--REFERENCES IN LAW.--As of the effective date of this act, all references in law to the Medicaid Provider Act shall be deemed to be references to the Medicaid Managed Care and Provider Act.